COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

CHILD CARE SERVICE APPEAL

NAME OF COMPLAINANT (PLEASE PRINT):
_____DATE: _____

ADDRESS:
_____
STREET/P.O. BOX NO. CITY STATE ZIP CODE

TELEPHONE NUMBER: _____COUNTY OF RESIDENCE: _____

PLEASE STATE IN DETAIL THE NATURE OF YOUR COMPLAINT AGAINST THE DEPARTMENT FOR COMMUNITY BASED SERVICES. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)

PLEASE IDENTIFY THE DATE OF THE DISPUTED CABINET ACTION: MONTH_____
DAY_____ YEAR_____

PLEASE IDENTIFY EACH CABINET STAFF PERSON INVOLVED WITH THE SUBJECT MATTER OF YOUR APPEAL. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)

Name:	Title, if known:
Work Address:	
City:	County:

Name:	Title, if known:
Work Address:	
City:	County:

<u>CONTINUE YOUR PAYMENTS</u>? YOU MAY HAVE TO PAY BACK THESE PAYMENTS, IF THE DECISION IS NOT IN YOUR FAVOR. I WANT MY SAME PAYMENTS CONTINUED UNTIL THE HEARING OFFICER MAKES A DECISION. CHECK YES _____ NO _____.

_____
Signature of Complainant Date

_____
Signature of Authorized Representative, if appropriate Date

To Request an Administrative Hearing for Appeal of a Cabinet Action, please complete this form and mail to: Cabinet for Health & Family Services, Division of Administrative Hearings, Families & Children Administrative Hearings Branch, 105 Sea Hero Rd, Suite 2, Frankfort, KY 40601.

If you need assistance with the completion of this form, contact the Division of Child Care at (502) 564-2524. **A REQUEST FOR AN ADMINISTRATIVE HEARING SHALL BE MAILED WITHIN 30 DAYS FROM THE DATE OF A CABINET ACTION.**